
Know how to describe peritoneal and hemodialysis.

Abbreviations: Add RP (retrograde pyelogram)

Chapter 7- Exercises: D, F, G, I and J

URINARY TRACT INFECTIONS (UTIs)

About 25-35% of women between ages 20 and 40 have urinary tract infections. Before the age of 50, men are much less likely to have the infections, but after age 50, UTIs in men begin to rise until they are almost equal with women. One reason women have more infections than men is that the opening to a woman's urinary tract, the urethra, is closer to the anus than is a man's. Bacteria can be more easily deposited in a woman's urinary tract. Researchers speculate that some women have cells lining their urinary tract that are more receptive to bacteria than normal. There are also genetic factors associated with UTIs.

Studies agree that women who have more than two UTIs a year should consider low-dose antibiotics. In a February 1991 study in the journal Review of Infectious Disease, Dr. Walter Stamm, professor of medicine at the University of Washington School of Medicine, followed 51 women with recurrent infections for nine years. They had 770 infections with 2819 clinic visits. Use of low-dose antibiotics reduced the rates of bladder infection and prevented kidney infection. The three antibiotics tested, taken at a strength of 100 milligrams daily, were equally effective.

The study concluded that the effectiveness of the antibiotics remained constant for a five-year period without serious adverse reactions. After therapy was stopped, the infection rate usually returned to the level before therapy started.
INTERSTITIAL CYSTITIS

Cystitis is a poorly understood bladder disease that affects women disproportionately. The cause of interstitial cystitis is unknown, although possibilities include infection, a defect in the bladder's lining, and an autoimmune response. The bladder shrinks, causing the patient to urinate as frequently as every 20 minutes, day and night, often leading to chronic sleep deprivation and depression. Pain is present not only in the bladder, but in the back, abdomen, vagina, and urethra. Sexual intercourse is uncomfortable.

About half of patients affected cannot hold a full-time job. Unlike other types of urinary tract infections, interstitial cystitis does not respond to antibiotics. Though the condition will go into remission, there is no cure. Some patients obtain relief with diet therapy, painkillers, and anti-inflammatory drugs. In the worst cases, the bladder must be removed.

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SAMPLE Discharge Summary

Discharge Diagnosis:
- Pyelonephritis
- Cystitis
- Urinary retention

Operations/Procedures:
- I.V. fluid hydration
- I.V. antibiotics
- Urinary catheterization

History: 43 year old married male with a history of post-traumatic stress disorder, peptic acid disease, knee degeneration, cholesterol elevation and cigarette smoking. Patient developed frequent urination approximately two days prior to admission. The day before admission he developed headache, several urinary symptoms, with severe urgency and small of urine output.

Physical Findings: Middle-aged male who was doubled over and being supported by his wife. He was moving slowly. Abdomen soft and flat with hypoactive tones. He has suprapubic tenderness. On exam, there was tenderness in the urethra and seminal vessels.

Laboratory & X-Ray: An EKG was done because of a history of MI at age 28. EKG showed no evidence of an MI. Cardiologist interpretation is pending. Urine culture grew out greater than 100,000 E.coli. They were sensitive to all antibiotics tested. His electrolytes were checked daily and were in a reasonable range. Creatinine varied from 0.8 to 1.0. His initial U/A showed greater than 200 wbc’s, 40-60 rbc’s, and 4+ bacteria. The wbc count peaked on April 25th with 19,200 wbc’s, 74 segs, and 17 bands. On April 28th, the wbc count was 4,600 with 65 segs and 6 bands.

Consultations: None

Course in Hospital: Patient was intially put on I.V. fluid hydration and I.V. Septra. Penicillins were not used because patient has history of penicillin allergy. On questioning the patient further, the allergy was diagnosed by the same elderly physician who diagnosed the M.I. The patient had been taking no Penicillin prior to the diagnosis and did not have any hives, rash, edema or other symptoms when the diagnosis was made, therefore, there is some doubt about the validity of the diagnosis. Patient developed urinary retention and was catheterized. He showed post-void residuals ranging from 200-500 cc’s. He gradually improved over the course of the admission, but still had problems with post-void residual. His antibiotic was switched from Septra to Cipro 500 mg. p.o. b.i.d. He continued to improve and post-void residuals decreased. On April 28th, the post-void residuals were in the 40-120 cc range. Patient was anxious to go home and was discharged.
Condition at discharge: stable. Diet: normal. Activities: encouraged. Medications: Cipro 500 mg. b.i.d. for 8 additional days. Follow up: lab work repeated until the sed rate is resolved. Urine culture 4 days after the course of Cipro.